An act to amend Sections 14301.1 and 14592 of, and to amend, repeal, and add Section 14593 of, the Welfare and Institutions Code, relating to Medi-Cal.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14301.1 of the Welfare and Institutions Code, as amended by Section 28 of Chapter 37 of the Statutes of 2013, is amended to read:

14301.1. (a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health-plan- and county-specific rates. Notwithstanding any other law, this section shall apply to any managed care organization, licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), that has contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7 to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS for rates established on or after July 1, 2012. The department shall utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

(1) Health-plan-specific encounter and claims data.

(2) Supplemental utilization and cost data submitted by the health plans.

(3) Fee-for-service data for the underlying county of operation or other appropriate counties as deemed necessary by the department.

(4) Department of Managed Health Care financial statement data specific to Medi-Cal operations.

(5) Other demographic factors, such as age, gender, or diagnostic-based risk adjustments, as the department deems appropriate.

(b) To the extent that the department is unable to obtain sufficient actual plan data, it may substitute plan model, similar plan, or county-specific fee-for-service data.

(c) The department shall develop rates that include administrative costs, and may apply different administrative costs with respect to separate aid code groups.

(d) The department shall develop rates that shall include, but are not limited to, assumptions for underwriting, return on investment, risk, contingencies, changes in policy, and a detailed review of health plan financial statements to validate and reconcile costs for use in developing rates.

(e) The department may develop rates that pay plans based on performance incentives, including quality indicators, access to care, and data submission.

(f) The department may develop and adopt condition-specific payment rates for health conditions, including, but not limited to, childbirth delivery.

(g) (1) Prior to finalizing Medi-Cal managed care capitation rates, the department shall provide health plans with information on how the rates were developed, including rate sheets for that specific health plan, and provide the plans with the opportunity to provide additional supplemental information.

(2) For contracts entered into between the department and any entity pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7, the department, by June 30 of each year, or, if the budget has not passed by that date, no later than five

working days after the budget is signed, shall provide preliminary rates for the upcoming fiscal year.

(h) For the purposes of developing capitation rates through implementation of this ratesetting methodology, Medi-Cal managed care health plans shall provide the department with financial and utilization data in a form and substance as deemed necessary by the department to establish rates. This data shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the Government Code as contained in the California Public Records Act (Division 7 (commencing with Section 6250) of Title 1 of the Government Code).

(i) Notwithstanding any other ~~provision of~~ law, on and after the effective date of the act adding this subdivision, the department may apply this section to the capitation rates it pays under any managed care health plan contract.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may set and implement managed care capitation rates, and interpret or make specific this section and any applicable federal waivers and state plan amendments by means of plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

(k) The department shall report, upon request, to the fiscal and policy committees of the respective houses of the Legislature regarding implementation of this section.

(*l*) Prior to October 1, 2011, the risk-adjusted countywide capitation rate shall comprise no more than 20 percent of the total capitation rate paid to each Medi-Cal managed care plan.

(m) (1) It is the intent of the Legislature to preserve the policy goal to support and strengthen traditional safety net providers who treat high volumes of uninsured and Medi-Cal patients when Medi-Cal enrollees are defaulted into Medi-Cal managed care plans.

(2) As the department adds additional factors, such as managed care plan costs, to the Medi-Cal managed care plan default assignment algorithm, it shall consult with the Auto Assignment Performance Incentive Program stakeholder workgroup to develop cost factor disregards related to intergovernmental transfers and required wraparound payments that support safety net providers.

(n) (1) The department shall develop and pay capitation rates to entities contracted pursuant to Chapter 8.75 (commencing with Section 14591), using actuarial methods and in a manner consistent with this section, except as provided in this subdivision.

(2) The department may develop capitation rates using a standardized rate methodology across managed care plan models for comparable populations.

(3) The department may develop statewide rates and apply geographic adjustments, using available data sources deemed appropriate by the department.

(4) Rates developed pursuant to this subdivision shall reflect the level of care associated with the specific populations served under the contract.

(5) The department shall consult with those entities contracted pursuant to Chapter 8.75 (commencing with Section 14591) in developing a rate methodology according to this subdivision.

(6) During the first two rate years in which the methodology developed pursuant to this subdivision is used by the department to set rates for entities contracted pursuant

to Chapter 8.75 (commencing with Section 14591), the department, in its sole discretion, may pay the entity at any rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (7), and for the purpose of mitigating impact to the entity during the transition to the methodology developed pursuant to this subdivision.

(7) This subdivision shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available.

(8) This subdivision shall apply for rates implemented no earlier than January 1, 2017.

~~(n)~~

(o) This section shall be inoperative if the Coordinated Care Initiative becomes inoperative pursuant to Section 34 of ~~the act that added this subdivision.~~ Chapter 37 of the Statutes of 2013.

SEC. 2. Section 14301.1 of the Welfare and Institutions Code, as added by Section 29 of Chapter 37 of the Statutes of 2013, is amended to read:

14301.1. (a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health-plan- and county-specific rates. The department shall utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91

(commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

(1) Health-plan-specific encounter and claims data.

(2) Supplemental utilization and cost data submitted by the health plans.

(3) Fee-for-service data for the underlying county of operation or other appropriate counties as deemed necessary by the department.

(4) Department of Managed Health Care financial statement data specific to Medi-Cal operations.

(5) Other demographic factors, such as age, gender, or diagnostic-based risk adjustments, as the department deems appropriate.

(b) To the extent that the department is unable to obtain sufficient actual plan data, it may substitute plan model, similar plan, or county-specific fee-for-service data.

(c) The department shall develop rates that include administrative costs, and may apply different administrative costs with respect to separate aid code groups.

(d) The department shall develop rates that shall include, but are not limited to, assumptions for underwriting, return on investment, risk, contingencies, changes in policy, and a detailed review of health plan financial statements to validate and reconcile costs for use in developing rates.

(e) The department may develop rates that pay plans based on performance incentives, including quality indicators, access to care, and data submission.

(f) The department may develop and adopt condition-specific payment rates for health conditions, including, but not limited to, childbirth delivery.

(g) (1) Prior to finalizing Medi-Cal managed care capitation rates, the department shall provide health plans with information on how the rates were developed, including rate sheets for that specific health plan, and provide the plans with the opportunity to provide additional supplemental information.

(2) For contracts entered into between the department and any entity pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7, the department, by June 30 of each year, or, if the budget has not passed by that date, no later than five working days after the budget is signed, shall provide preliminary rates for the upcoming fiscal year.

(h) For the purposes of developing capitation rates through implementation of this ratesetting methodology, Medi-Cal managed care health plans shall provide the department with financial and utilization data in a form and substance as deemed necessary by the department to establish rates. This data shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the Government Code as contained in the California Public Records Act (Division 7 (commencing with Section 6250) of Title 1 of the Government Code).

(i) The department shall report, upon request, to the fiscal and policy committees of the respective houses of the Legislature regarding implementation of this section.

(j) Prior to October 1, 2011, the risk-adjusted countywide capitation rate shall comprise no more than 20 percent of the total capitation rate paid to each Medi-Cal managed care plan.

(k) (1) It is the intent of the Legislature to preserve the policy goal to support and strengthen traditional safety net providers who treat high volumes of uninsured and Medi-Cal patients when Medi-Cal enrollees are defaulted into Medi-Cal managed care plans.

(2) As the department adds additional factors, such as managed care plan costs, to the Medi-Cal managed care plan default assignment algorithm, it shall consult with the Auto Assignment Performance Incentive Program stakeholder workgroup to develop cost factor disregards related to intergovernmental transfers and required wraparound payments that support safety net providers.

(l) (1) The department shall develop and pay capitation rates to entities contracted pursuant to Chapter 8.75 (commencing with Section 14591), using actuarial methods and in a manner consistent with this section, except as provided in this subdivision.

(2) The department may develop capitation rates using a standardized rate methodology across managed care plan models for comparable populations.

(3) The department may develop statewide rates and apply geographic adjustments, using available data sources deemed appropriate by the department.

(4) Rates developed pursuant to this subdivision shall reflect the level of care associated with the specific populations served under the contract.

(5) The department shall consult with those entities contracted pursuant to Chapter 8.75 (commencing with Section 14591) in developing a rate methodology according to this subdivision.

(6) During the first two rate years in which the methodology developed pursuant to this subdivision is used by the department to set rates for entities contracted pursuant

to Chapter 8.75 (commencing with Section 14591), the department, in its sole discretion, may pay the entity at any rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (7), and for the purpose of mitigating impact to the entity during the transition to the methodology developed pursuant to this subdivision.

(7) This subdivision shall be implemented only to the extent any necessary federal approvals are obtained and federal financial participation is available.

(8) This subdivision shall apply for rates implemented no earlier than January 1, 2017.

~~(l)~~

(m) This section shall be operative only if Section 28 of the act that added this section becomes inoperative pursuant to subdivision (n) of that Section 28.

SEC. 3. Section 14592 of the Welfare and Institutions Code is amended to read:

14592. (a) For purposes of this chapter, "PACE organization" means an entity as defined in Section 460.6 of Title 42 of the Code of Federal Regulations.

(b) The Director of Health Care Services shall establish the California Program of All-Inclusive Care for the Elderly, to provide community-based, risk-based, and capitated long-term care services as optional services under the state's Medi-Cal State Plan and under contracts entered into between the federal Centers for Medicare and Medicaid Services, the department, and PACE organizations, meeting the requirements of the Balanced Budget Act of 1997 (Public Law 105-33) and ~~Part 460 (commencing with Section 460.2) of Title 42 of the Code of Federal Regulations.~~ any other applicable law or regulation.

SEC. 4. Section 14593 of the Welfare and Institutions Code is amended to read:

14593. (a) (1) The department may enter into contracts with public or private ~~nonprofit~~ organizations for implementation of the PACE program, and also may enter into separate contracts with PACE organizations, to fully implement the single state agency responsibilities assumed by the department in those contracts, Section 14132.94, and any other state requirement found necessary by the department to provide comprehensive community-based, risk-based, and capitated long-term care services to California's frail elderly.

(2) The department may enter into separate contracts as specified in subdivision (a) with up to 15 PACE organizations. This paragraph shall become inoperative upon federal approval of a capitation rate methodology, pursuant to subdivision (n) of Section 14301.1.

(b) The requirements of the PACE model, as provided for pursuant to Section 1894 (42 U.S.C. Sec. 1395eee) and Section 1934 (42 U.S.C. Sec. 1396u-4) of the federal Social Security Act, shall not be waived or modified. The requirements that shall not be waived or modified include all of the following:

(1) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

(2) The delivery of comprehensive, integrated acute and long-term care services.

(3) The interdisciplinary team approach to care management and service delivery.

(4) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

(5) The assumption by the provider of full financial risk.

(6) The provision of a PACE benefit package for all participants, regardless of source of payment, that shall include all of the following:

(A) All Medicare-covered items and services.

(B) All Medicaid-covered items and services, as specified in the state's Medicaid plan.

(C) Other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

(c) Sections 14002, 14005.12, 14005.17, and 14006 shall apply when determining the eligibility for Medi-Cal of a person receiving the services from an organization providing services under this chapter.

(d) Provisions governing the treatment of income and resources of a married couple, for the purposes of determining the eligibility of a nursing-facility certifiable or institutionalized spouse, shall be established so as to qualify for federal financial participation.

(e) (1) The department shall establish capitation rates paid to each PACE organization at no less than 95 percent of the fee-for-service equivalent cost, including the department's cost of administration, that the department estimates would be payable for all services covered under the PACE organization contract if all those services were to be furnished to Medi-Cal beneficiaries under the fee-for-service Medi-Cal program provided for pursuant to Chapter 7 (commencing with Section 14000).

(2) This subdivision shall be implemented only to the extent that federal financial participation is available.

(3) This subdivision shall become inoperative upon federal approval of a capitation rate methodology, pursuant to subdivision (n) of Section 14301.1.

(f) Contracts under this chapter may be on a nonbid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

~~(g) This section shall become operative on April 1, 2015.~~

(g) (1) Notwithstanding subdivision (b), and only to the extent federal financial participation is available, the department, in consultation with PACE organizations, shall seek increased federal regulatory flexibility from the Centers for Medicare and Medicaid Services to modernize the PACE program, which may include, but is not limited to, addressing all of the following:

(A) Composition of PACE interdisciplinary teams (IDT).

(B) Frequency of PACE IDT meetings.

(C) Use of alternative care settings.

(D) Use of community-based physicians.

(E) Marketing practices.

(F) Development of a streamlined PACE waiver process.

(2) This subdivision shall be operative upon federal approval of a capitation rate methodology pursuant to subdivision (n) of Section 14301.1.

(h) This section shall become inoperative if the Coordinated Care Initiative becomes inoperative pursuant to Section 34 of Chapter 37 of the Statutes of 2013, and shall be repealed on January 1 next following the date upon which it becomes inoperative.

SEC. 5. Section 14593 is added to the Welfare and Institutions Code, to read:

14593. (a) (1) The department may enter into contracts with public or private organizations for implementation of the PACE program, and also may enter into separate contracts with PACE organizations, to fully implement the single state agency responsibilities assumed by the department in those contracts, Section 14132.94, and any other state requirement found necessary by the department to provide comprehensive community-based, risk-based, and capitated long-term care services to California's frail elderly.

(2) The department may enter into separate contracts as specified in subdivision (a) with up to 15 PACE organizations. This paragraph shall become inoperative upon federal approval of a capitation rate methodology pursuant to subdivision (*l*) of Section 14301.1.

(b) The requirements of the PACE model, as provided for pursuant to Section 1894 (42 U.S.C. Sec. 1395eee) and Section 1934 (42 U.S.C. Sec. 1396u-4) of the federal Social Security Act, shall not be waived or modified. The requirements that shall not be waived or modified include all of the following:

(1) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

(2) The delivery of comprehensive, integrated acute and long-term care services.

(3) The interdisciplinary team approach to care management and service delivery.

(4) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

(5) The assumption by the provider of full financial risk.

(6) The provision of a PACE benefit package for all participants, regardless of source of payment, that shall include all of the following:

(A) All Medicare-covered items and services.

(B) All Medicaid-covered items and services, as specified in the state's Medicaid plan.

(C) Other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

(c) Sections 14002, 14005.12, 14005.17, and 14006 shall apply when determining the eligibility for Medi-Cal of a person receiving the services from an organization providing services under this chapter.

(d) Provisions governing the treatment of income and resources of a married couple, for the purposes of determining the eligibility of a nursing-facility certifiable or institutionalized spouse, shall be established so as to qualify for federal financial participation.

(e) (1) The department shall establish capitation rates paid to each PACE organization at no less than 95 percent of the fee-for-service equivalent cost, including the department's cost of administration, that the department estimates would be payable for all services covered under the PACE organization contract if all those services were to be furnished to Medi-Cal beneficiaries under the fee-for-service Medi-Cal program provided for pursuant to Chapter 7 (commencing with Section 14000).

(2) This subdivision shall be implemented only to the extent that federal financial participation is available.

(3) This subdivision shall become inoperative upon federal approval of a capitation rate methodology pursuant to subdivision (*l*) of Section 14301.1.

(f) Contracts under this chapter may be on a nonbid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(g) (1) Notwithstanding subdivision (b), and only to the extent federal financial participation is available, the department, in consultation with PACE organizations, shall seek increased federal regulatory flexibility from the Centers for Medicare and Medicaid Services to modernize the PACE program, which may include, but is not limited to, addressing:

(A) Composition of PACE interdisciplinary teams (IDT).

(B) Frequency of PACE IDT meetings.

(C) Use of alternative care settings.

(D) Use of community-based physicians.

(E) Marketing practices.

(F) Development of a streamlined PACE waiver process.

(2) This subdivision shall be operative upon federal approval of a capitation rate methodology pursuant to subdivision (*l*) of Section 14301.1.

(h) This section shall become operative only if Section 28 of Chapter 37 of the Statutes of 2013 becomes inoperative.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Program of All-Inclusive Care for the Elderly.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions.

Existing federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals so that they may continue living in the community. Federal law authorizes states to implement the PACE program as a Medicaid state option. Existing law authorizes the department to enter into contracts with up to 15 PACE organizations, as defined, to implement the PACE program, as specified. Existing law, on and after April 1, 2015, requires the department to establish capitation rates paid to each PACE organization at no less than 95% of the fee-for-service equivalent cost, including the department's cost of administration, that

the department estimates would be payable for all services covered under the PACE organization contract if all those services were to be furnished to Medi-Cal beneficiaries under the fee-for-service program.

This bill would require the department to develop and pay capitation rates to contracted PACE organizations, for rates implemented no earlier than January 1, 2017, in accordance with criteria specific to those organizations, based on, among other things, standardized rate methodologies for similar populations, adjustments for geographic location, and the level of care being provided.

This bill also would authorize the department, to the extent federal financial participation is available to seek increased federal regulatory flexibility to modernize the PACE program, as specified. Implementation of the new capitation rate methodology would be contingent on receipt of federal approval and the availability of federal financial participation. The bill would provide alternative rate capitation methodologies, depending upon whether or not the Coordinated Care Initiative is operative, as specified.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.